CASE WESTERN RESERVE UNIVERSITY
SCHOOL OF MEDICINE

University Hospitals
Case Medical Center

Request for Transcript

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I hereby request a copy of my transcript of CME activities sponsored by:
University Hospitals of Cleveland _____
Case Western Reserve University _____
Both _____
from _____/_____/_____ through _____/_____/_____. (transcript request dates)

Requests for transcripts of CME activities with dates of 01/01/05 and after will be assessed a $25.00 transcript fee.

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Please mail to the above address _____
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Fax this request to: 216-844-8133 or
Mail this request to: Case/UHHS Continuing Medical Education Program
10524 Euclid Avenue, Cleveland, OH 44106-6026
Any questions: please contact 216-844-5050
Please allow up to one week for processing.